

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01917					01898									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY Garrett					a. STATE Md.									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Swanton					b. COUNTY Garrett									
c. LENGTH OF STAY IN 1b 59 Yrs					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Rural-Swanton									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3 Mi.E. of Swanton					d. STREET ADDRESS 3 Mi.E. Swanton									
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED					4. DATE OF DEATH									
(Type or print) First Middle Last Curtley Harrison Barnard					Month Day Year Feb. 14 1962									
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Jan. 13, 1903		59 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
Miner			Coal Mine			Garrett Maryland			U.S.A.					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
William O. Barnard					Louisa Paugh									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT				
no					208-07-4142					Dessie D. Barnard-R.D. 1 Swanton, Ms.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung with metastasis										8 mos.				
163X DUE TO														
Conditions, if any, which gave rise to immediate cause (b)														
(a), stating the underlying cause last. DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)				
Hour e.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>										
21. I certify that (I) (this hospital) attended the deceased from June....., 1961 to Feb....., 1962 that (I) (we) last saw the deceased alive on 1-10-62....., and that death occurred at.....M, from the causes and on the date stated above.														
22a. SIGNATURE James H. Feaster, Jr., M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 2-15-62					
22c. PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M.D.						22d. ADDRESS D. Oakland, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county)			(State)			
Burial			2/16/62		Turner Cem.			Garrett County			Md.			
24. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Ed Boul						Westernport, Md.			FEB 19 '62			Arthur S. Kline		

01888

01888

M

POSTED

[Handwritten signature]

James H. [illegible]

Westport, Me.

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1

VR A15 (4)
ISM 9/60

M

I

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
1. PLACE OF DEATH				2. USUAL RESIDENCE			
a. COUNTY Garrett				a. STATE Md.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				b. COUNTY Garrett			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last				Month Day Year			
Robert Monore Broadwater				Feb. 16 1962			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Nov. 17, 1899	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
62 yrs.		Laborer		Paper Mill		Garrett Co. Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
U.S.A.		Frederick Broadwater		Ellen Wilt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no		217-05-0224		Mrs. Savilla Broadwater			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				ca. 1 year			
DUE TO				6 mo			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED			
Hour a.m. p.m.				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
19				20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)			
20f. (City or town)				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1961 to Feb 16 1962, that (I) (we) last saw the deceased alive on Feb 14 1962, and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
James A. Wolverton, Sr.				2/16/62			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
James A. Wolverton, Sr.				Piedmont, W. Va.			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF			
Burial				2/18/62			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county)			
Broadwater				Garrett Md.			
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
E. L. Boal				FEB 20 '62			
25b. REGISTRAR'S SIGNATURE							
Westernport, Md.				Arthur J. Farris			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01919

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01800

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MT LAKE PARK, MD</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X MT LAKE PARK, MD</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>MARTIN</u> Last <u>COX</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>9</u> Year <u>1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 23, 1899</u>	
9. AGE (In years last birthday) <u>62 yrs.</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNEMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>GREENWOOD DEL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARTIN COX</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>171-10-5059</u>		17. INFORMANT <u>Mr. Ethel Cox, Mt Lake Park, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Previous Coronary Occlusion</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES H. FEASTER, JR</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
ADDRESS (Street, city, town, or county) <u>OAK, MD</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/12/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GRANTSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>GRANTSVILLE, GARRETT CO MD</u>	
23. FUNERAL DIRECTOR <u>Don Newman, Grantsville, MD</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 14 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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Handy

11-1-12

Wichita

Martin Cox

Unknown

11-10-12

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Wichita

Wichita

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Wichita

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT. **M** **X** **I** **0** **2** **ff**

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01920 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01901

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Crellin d. STREET ADDRESS 1		
3. NAME OF DECEASED (Type or print) Sara Naomia Dilley			4. DATE OF DEATH Month Feb. Day 21st. Year 19 62		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1886	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Bittering, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John Lohr		
14. MOTHER'S MAIDEN NAME Eva Myers			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. 212-38-6567B			17. INFORMANT Glennroot Dilley Address Baltimore, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) 420.1 DUE TO (c) 420.1 DUE TO cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month. Day. Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Oakland, Md. 2-21-62					
ACTUAL SIGNATURE James H. Feaster, Jr., M. D.		EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/25/62		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	
22d. LOCATION (City, town, or country) (State) Oakland, Maryland		23. FUNERAL DIRECTOR ADDRESS Gerald N. Minnich Oakland, Maryland			
24a. REC'D BY REGISTRAR DATE MAR 1 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

10810

10810



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01921

CERTIFICATE OF DEATH

01902

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELK GARDEN 85X-3 d. STREET ADDRESS 85X-3			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN Ib 2 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL							
3. NAME OF DECEASED (Type or print) First JOHN Middle JOSEPH Last DROPPLEMAN				4. DATE OF DEATH Month FEB. Day 27, Year 19 62			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 18, 1880	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY DROPPLEMAN				14. MOTHER'S MAIDEN NAME THRESA HARMAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No /////				16. SOCIAL SECURITY NO. 236/12/7946		17. INFORMANT JAMES DROPPLEMAN Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Terminal 4 4 3 X DUE TO Hypertensive Cardiovascular Disease with Hypertrophy & Congestive Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 1 month 10-12 yrs						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from FEB. 25, 19 62 to FEB. 27, 19 62 , that (I) (we) last saw the deceased alive on 26 Feb 1962 and that death occurred at 9:55 A M, from the causes and on the date stated above.							
22a. SIGNATURE Andrew E. Mance M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 27 Feb 62	
22c. PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.				22d. ADDRESS THIRD STREET OAKLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 3-2-62		23c. NAME OF CEMETERY OR CREMATORY TOOF		23d. LOCATION (City, town or county) (State) ELK Garden W Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert Kyle Britts Jr. Stignell, Md.				25a. REC'D BY REGISTRAR DATE MAR 5 '62		25b. REGISTRAR'S SIGNATURE Andrew E. Mance	

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01302

DATE

WEST VIRGINIA

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THE TOWN

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THU-SAT

THU-SAT

Handwritten notes and signatures, including "JAMES H. HARRIS" and "JAMES H. HARRIS".

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01922 CERTIFICATE OF DEATH 01903

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HUTTON Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X HUTTON	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GARRETT CO. MEMORIAL HOSPITAL		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last PAMELA DARLENE GANK		4. DATE OF DEATH Month Day Year FEBRUARY 5, 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 30, 1958
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (County & State, or foreign country) OAKLAND, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GAROLD GILBERT GANK	
14. MOTHER'S MAIDEN NAME BOWSER, GLORIA DELORES		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address GAROLD GILBERT GANK HUTTON, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE, ACUTE 754.5 DUE TO (b) Congenital Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 4-30, 1962, to 2-5, 1962, that (I) (we) last saw the deceased alive on 1-22-62, and that death occurred at 2:45 A.M. from the causes and on the date stated above. 22a. SIGNATURE [Signature] M.D. 22b. DATE SIGNED 2-5-62 22c. PHYSICIAN'S NAME (Type) DR. JAMES H. FEASTER, JR. 22d. ADDRESS OAKLAND, MARYLAND 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2-7-62 23c. NAME OF CEMETERY OR CREMATORY Garretts Co. Memorial Gardens 23d. LOCATION (City, town or county) (State) Garrett Md. 24. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Oakland, Maryland 25a. REC'D BY REGISTRAR DATE FEB 13 '62 25b. REGISTRAR'S SIGNATURE [Signature]			

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Charles G. ...
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01923 CERTIFICATE OF DEATH 01904

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Preston</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett Co. Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Victoria</u> Middle <u>Regina</u> Last <u>Haskiell</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1878</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Sines</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Wilhelm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>George Haskiell</u>		Address <u>Turner-Douglas, W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Rt Terminal</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Myocardial failure & Decomposition</u> DUE TO (c) <u>Aspirated solids</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>DEC. 10, 1961</u> to <u>FEB. 7, 1962</u> , that (I) (we) last saw the deceased alive on <u>FEB. 7, 1962</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>A.E. Mance</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A.E. MANCE, M.D.</u>		22d. ADDRESS <u>THIRD STREET OAKLAND, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/9/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ashby Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Garrett Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gerald N. Minnich</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 13 '62</u>	
ADDRESS <u>Oakland, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

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01904

CONFIDENTIAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01924

01905

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland, c. LENGTH OF STAY IN b 4 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cuppett-Weeks Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia b. COUNTY Marion c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fairmont, d. STREET ADDRESS 85X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Andrew Heim		4. DATE OF DEATH Month February Day 21, Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1878
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work, if any, and the business or industry done during most of working life, even if retired) Public School Teachers	
11. BIRTHPLACE (County & State, or foreign country) Wilkes Barre, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Heim		14. MOTHER'S MAIDEN NAME Emma ---?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 235-46-1823	
17. INFORMATION John Heim - 950 Coleman Ave., Fairmont,		Address W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced Arterio Sclerotic 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/16/62 to 2/21/62 , that (I) (we) last saw the deceased alive on 2/16/62 , and that death occurred 12:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE E. I. Baumgartner M.D. 22c. PHYSICIAN'S NAME (Type) E. I. Baumgartner, M.D.		22b. ADDRESS Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/23/1962	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town or county) (State) Fairmont, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR DATE FEB 26 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

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Garrett

Oakland

4 yrs.

Patience

Marion

Suggest - 7000 Nursing Home

John

Andrew

Hein

Portway St.

82

Miss White

X

805 So. 18th St.

College, Richmond Teachers

Caroline, 812 1/2 S. 10th St., W. 8. A. A. Wilkes, 10th St., 10th St.

Martin Hein

same

805-46-1803 John Hein - 805 Coleman Ave., Richmond

805-46-1803 John Hein - 805 Coleman Ave., Richmond

805-46-1803

Oakland, Md.

W. I. Cunningham, E. D.

Richmond, W. Va.

Woodman Company

Oakland, Md.

Hein

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01925

CERTIFICATE OF DEATH

01906

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,			c. LENGTH OF STAY IN 1b 4 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL			X ACCIDENT		
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HOWARD Last KELSO			4. DATE OF DEATH Month FEBRUARY Day 22 Year 19 62		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 1, 1885	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FARMER			10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (County & State, or foreign country) BOYNTON, PA.
13. FATHER'S NAME JIM KELSO			14. MOTHER'S MAIDEN NAME ELIZABETH PLATTER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 220-07-8089		
17. INFORMANT Mrs. Oma Leydig			Address Accident, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) sepsis 610X DUE TO (b) Chc pylonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Obstructive prostatic hypertrophy					INTERVAL BETWEEN ONSET AND DEATH 3 days. 6 mos. + 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 1961 , to Feb. 1962 that (I) (we) last saw the deceased alive on 21 Feb. 1962 and that death occurred at 1:55 PM from the causes and on the date stated above.					
22a. SIGNATURE B. L. GRANT M.D.			22b. DATE SIGNED 2/22/1962		
22c. PHYSICIAN'S NAME (Type) B. L. GRANT M.D.			22d. ADDRESS OAKLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/25/1962	23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION (City, town or county) Accident, Md. (State)
24. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton			25a. REC'D BY REGISTRAR DATE FEB 26 '62		
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas					

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ACCIDENT

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EXCESSIVE DRIVING

PROPERTY OF THE COUNTY

DRIVING

DRIVING, 1, 1915

OWN FORM

OWN FORM

ILLUSTRATION BY WATER

ILLUSTRATION BY WATER

220-07-3008 Mr. Dan J. J. Anderson, Md.

no

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Accident, Md. 2/25/1962

Accident, Md.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01926

01907

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Grantsville, Md.				c. LENGTH OF STAY IN 1b 7 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Goodwill Mennonite Home Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ettie Middle M. Last Kight				4. DATE OF DEATH Month Feb. Day 20 Year 1962			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1866	
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas L. Shrader				14. MOTHER'S MAIDEN NAME Laura Kincaid			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address Mrs. Leah Huffman Blauvelt, N. Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 334 X IMMEDIATE CAUSE (a) Chronic brain syndrome DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 7 mos. 10 yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 1, 1961 to Feb. 20, 1962 , that (I) (we) last saw the deceased alive on 2/19/62 19 1962 , and that death occurred at 12:00 AM , from the causes and on the date stated above.							
22a. SIGNATURE A. Paige Strong				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb. 20, 1962	
22c. PHYSICIAN'S NAME (Type) A. Paige Strong				22d. ADDRESS Grantsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 23, 1962		23c. NAME OF CEMETERY OR CREMATORY Davis Cemetery		23d. LOCATION (City, town, or county) (State) Davis, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR FEB 23 '62	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, (Pages 1 and 2) and send them to the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Handwritten signature

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01927 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01908											
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Swanton Rt. 2 d. STREET ADDRESS Swanton Rt. 2					
3. NAME OF DECEASED (Type or print) Laura Virgie Liller						4. DATE OF DEATH Month Feb. Day 3 Year 19 62					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1887		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 3 Days 19 Hours 62 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Swanton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Uphole						14. MOTHER'S MAIDEN NAME Lydia Thomas					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Melvin Friend		Address Swanton Rt. 2, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis DUE TO (b) Ruptured Carcinoma of Sigmoid Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting DATE SIGNED 2/5/62 Oakland, Md. Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/5/62		22c. NAME OF CEMETERY OR CREMATORY Glendale Cemetery		22d. LOCATION (City, town, or country) Garrett Maryland			
23. FUNERAL DIRECTOR NAME (Type) Gerald N. Minnich ADDRESS Oakland, Maryland						24a. REC'D BY REGISTRAR DATE FEB 13 '62		24b. REGISTRAR'S SIGNATURE Charles E. Hanks			

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STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01928

01909

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION L St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Henry Last McRobie				4. DATE OF DEATH Month Feb. Day 28 Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1899	
9. AGE (In years lost birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 62 Days 28 Hours 19 Min.		11. IF UNDER 24 HRS. Months 62 Days 28 Hours 19 Min.		12. IF UNDER 24 HRS. Months 62 Days 28 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Oakland, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME William H. McRobie			
14. MOTHER'S MAIDEN NAME Alice Nair				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 220-16-5671				17. INFORMANT Mrs. Helen McRobie Address Mt. Lake Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Dis DUE TO (c) 2 yrs.				INTERVAL BETWEEN ONSET AND DEATH 3 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 17 Apr 1962 to 28 Feb 1962 and that death occurred at 7 p. M. from the causes and on the date stated above.				22a. SIGNATURE B. L. Grant			
22b. PHYSICIAN NAME (Type) B. L. Grant				22c. ADDRESS 3 rd. St. Oakland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/3/62			
23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery				23d. LOCATION (City, town, or county) (State) Oakland, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich				25a. REC'D BY REGISTRAR DATE MAR 7 '62			
25b. REGISTRAR'S SIGNATURE Arthur L. Thorne							

01903

CERTIFICATE OF DEATH

11928

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CHURCHILL

WYDELL

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Va. b. COUNTY Mineral			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY in 1b 8 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cuppert-Weeks Nursing Home				d. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) First Middle Last Jacob H. Metcalf				4. DATE OF DEATH Month Day Year Feb. 24th 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1873	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rt. Clerk				10b. KIND OF BUSINESS OR INDUSTRY B & O RR		11. BIRTHPLACE (State or foreign country) Mineral County, W. Va.	
12. CITIZEN OF WHAT COUNTRY U.S.A.							
13. FATHER'S NAME Benton Metcalf				14. MOTHER'S MAIDEN NAME Virginia Sultser			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Claude H. Metcalf				Address Antioch, West Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 ACUTE CARDIAC FAILURE; PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (b) CHRONIC MYOCARDITIS (a), stating the underlying cause last. (c) CORONARY SCLEROSIS; AORTIC VALVE CALCIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 52-10 Min. Years Years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE James H. Feaster, Jr.				DATE SIGNED			
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.				Address (Street, city, town, or county) Oak., Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 27, 1962		22c. NAME OF CEMETERY OR CREMATORY Queens Point		22d. LOCATION (City, town, or county) (State) Keyser, West Va.	
23. FUNERAL DIRECTOR Geo. K. Chambers				ADDRESS Keyser, West Va.			
24a. REC'D BY REGISTRAR FEB 28 '62				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01930

CERTIFICATE OF DEATH

Reg. Dist. No. 01911

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Grantsville, Md.		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Goodwill Mennonite Home Inc.		d. STREET ADDRESS 8 Frost Avenue	
3. NAME OF DECEASED (Type or print) First Mary Middle Jane Last Prichard		4. DATE OF DEATH Month Feb. Day 10 Year 1962	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1868
9. AGE (In years last birthday) 93		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Wales		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Thomas		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT E. I. Prichard, 69 Broadway, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic brain syndrome 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 months 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture left hip		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 1 , 19 61 , to Feb. 10 , 19 62 , that I last saw the deceased alive on Feb. 9 , 19 62 , and that death occurred at 5:00 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Grantsville, Md. DATE SIGNED Feb. 10, 1962			
ACTUAL SIGNATURE A. Paige Strong M.D.		DATE SIGNED Feb. 10, 1962	
PHYSICIAN'S NAME (Type) A. Paige Strong		Grantsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12/62	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montague		24a. REC'D BY REGISTRAR FEB 15 '62	
23. FUNERAL HOME 3 E. Main, Frostburg, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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01030

CERTIFICATE OF DEATH

01031

Married

Married

Residence: 1000 1st St. N. W. Washington, D. C.

John

John

April 1, 1963

White

Male

John

John

John

John

John

John

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01931

01912

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN TB 1 Day			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland Box 342			
				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Della Ann Savage				4. DATE OF DEATH Month Day Year February 2 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 21, 1895	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Hazelton, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Jackson Rodeheaver				14. MOTHER'S MAIDEN NAME Sarah Jane Manges			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. Thomas W. Savage			
17. INFORMANT Husband				Address Box 342 Oakland, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 6, 1960 to Feb. 1, 1962 , that (I) (was) last saw the deceased alive on Feb. 1, 1962 , and that death occurred at 6:15 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Joseph Alvarez				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb. 2, 1962	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph Alvarez				22d. ADDRESS Oakland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-4-62		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		23d. LOCATION (City, town or county) (State) Garrett Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich				ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR Feb 13 '62	
				25b. REGISTRAR'S SIGNATURE Arthur L. Huns			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01932
CERTIFICATE OF DEATH
01913

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland Rt. 1				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laura Middle Ellen Last Shaffer				4. DATE OF DEATH Month Feb. Day 11 Year 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1885	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Months 7 Days 10 Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Elgon, W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME David Winters				14. MOTHER'S MAIDEN NAME Lydia Snyder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT C. D. Shaffer, Jr. Address Oakland Rt. 1, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis heart disease. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 day 4 yrs -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10 Nov 1961 to 11 Feb 62 , 19 62 , that (I) (we) last saw the deceased alive on 10 Feb 1962 and that death occurred at 1 p.m. from the causes and on the date stated above.							
22a. SIGNATURE B. L. Grant				22b. DATE SIGNED 13 Feb 62			
22c. PHYSICIAN'S NAME (Type) B. L. Grant				22d. ADDRESS 3 rd. St. Oakland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/14/62		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		23d. LOCATION (City, town, or county) (State) Aurora W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich				ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR DATE FEB 15 '62	
				25b. REGISTRAR'S SIGNATURE Robert S. Kline			

01218

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01933

Item 8 Film G308 3/9/62 mb

01914

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDSVILLE,	
c. LENGTH OF STAY IN 1b 25 DAYS		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL WAKEFIELD		4. DATE OF DEATH Month Day Year FEBRUARY 27 19 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1870 MARCH 29, 1869
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED WOODSMAN		10b. KIND OF BUSINESS OR INDUSTRY CUT POSTS	
11. BIRTHPLACE (County & State, or foreign country) CUZERT W. VA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WAKEFIELD, ROBERT		14. MOTHER'S MAIDEN NAME FIKE, ELIZABETH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address Don Heinbaugh, Friendsville, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 450.00 DUE TO (b) RENAL FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cellulitis Right Hand	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct , 19 58 , to FEB , 19 62 , that (I) (we) last saw the deceased alive on Feb 27 , 19 62 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Pedro Rivera, MD		22b. DATE SIGNED 2-28-62	
22c. PHYSICIAN'S NAME (Type) DR. PEDRO RIVERA		22d. ADDRESS FRIENDSVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/2/62	
23c. NAME OF CEMETERY OR CREMATORY SAND SPRINGS		23d. LOCATION (City, town or county) (State) FRIENDSVILLE GARRETT CO MD	
24. FUNERAL DIRECTOR'S SIGNATURE Don Newman, GRANTSVILLE, MD		25. REC'D BY REGISTRAR MAR 6 '62	
25a. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01934						01915					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY GARRETT MARYLAND						a. STATE MARYLAND Garrett					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OAKLAND						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OAKLAND					
c. LENGTH OF STAY IN 1b 2 days						d. STREET ADDRESS 58 CENTER STREET					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last DEWEY MILLER WELCH						Month Day Year FEB. 16, 19 62					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 5, 1900		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Saw Mill				11. BIRTHPLACE (County & State, or foreign country) Sang Run, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES WELCH						14. MOTHER'S MAIDEN NAME NELLIE LOWDERMILK					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. 220-03-7318					
17. INFORMANT Lawrence Welch						Address Oakland Rt 1, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm. 0 23X DUE TO Lactic Acidosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 15 yr 4- DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT. 19 61 to 2/16/ 1962 , that (I) (we) last saw the deceased alive on 2/16/62 at 4:00 P , and that death occurred at 19 M, from the causes and on the date stated above.											
22a. SIGNATURE B.L. GRANT, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) B.L. GRANT, M.D.						22d. ADDRESS THIRD STREET OAKLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/19/62		23c. NAME OF CEMETERY OR CREMATORY Garrett Co. Memorial Gardens				23d. LOCATION (City, town or county) (State) Oakland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich						ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR FEB 20 '62		25b. REGISTRAR'S SIGNATURE G. N. Minnich	

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TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text block containing several lines of typed communication]

Handwritten: [Illegible signature]
Handwritten: [Illegible signature]

[Illegible text block, possibly a second page or continuation of the letter]

[Illegible text block at the bottom of the page, including what appears to be a date stamp and additional markings]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01935

CERTIFICATE OF DEATH

Reg. Dist. No. 01916

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kitzmiller</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kitzmiller</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 Church</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lona Mae Whetzel</u>				4. DATE OF DEATH Month Day Year <u>February 3 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/8/1879</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>WVA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilber W. Bolden</u>				14. MOTHER'S MAIDEN NAME <u>Elizebeth Lockard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Marj Anna Greaser Kitzmiller, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE: <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>Declarant said 5 yrs</u> <u>5 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 1956</u> , to <u>Feb. 3, 1962</u> , that I last saw the deceased alive on <u>Feb. 1, 1962</u> , and that death occurred at <u>6:30M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph Calandrella</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Kitzmiller, Md. Feb. 5-62</u>			
PHYSICIAN'S NAME (Type) <u>Ralph Calandrella</u>				<u>Kitzmiller MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/6/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nethken Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Elk Garden WVA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Kyle Priddy Jr.</u>				ADDRESS <u>Kitzmiller, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 7 '62</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinner</u>	

CERTIFICATE OF DEATH

1919

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT	
CAUSE OF DEATH		MANNER OF DEATH		DURATION OF ILLNESS		PREVAILING DISEASE		OTHER DISEASES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DEPUTY REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

RECEIVED
BUREAU OF VITAL RECORDS
JAN 10 1920